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Issue Date: 15 June 2006

CASE NO.: 2004-BLA-5857

In the Matter of:

ANDREW A. ULIBARRI,
Claimant,

v.

BASIN RESOURCES, INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Jonathan Wilderman, Esq.
For the Claimant

Ryan A. McManis, Esq.
For the Employer

Lindsay McCleskey, Esq.
For the Director

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

Statement of the Case

This proceeding involves a subsequent claim for benefits under the Black Lung Benefits Act ("Act") as amended, 30 U.S.C. §§ 901 *et seq*. Claimant filed his claim after January 19,

2001. The claim is therefore governed by 20 C.F.R. Part 718 (2004).[1] Because Claimant last worked in Colorado, the claim is subject to the law of the Tenth Circuit Court of Appeals. *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-202 (1989) (en banc).

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of death. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

Issues

1. Whether Claimant has proved that he is totally disabled?
2. Whether such disability, if proved, resulted from Claimant's pneumoconiosis?
3. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309?

Procedural History

Claimant, Andrew A. Ulibarri, first filed for Black Lung benefits on December 28, 1995. DX 1. A claims examiner denied the claim on March 12, 1996 based on Claimant's failure to establish total disability due to pneumoconiosis. *Id.* Claimant did not appeal and the denial became final.

Claimant again filed for benefits on March 14, 2000. DX 2. A claims examiner denied this second claim on August 23, 2000, again based on Claimant's failure to establish total disability due to pneumoconiosis. *Id.* Claimant again did not appeal the decision and the decision became final.

Claimant filed his instant claim for benefits on October 23, 2002.[2] DX 4. A Proposed Decision and Order – Award of Benefits was issued by the District Director on November 4, 2003. DX 25. Employer thereafter requested a formal hearing on December 4, 2003, and the matter was referred to the Office of Administrative Law Judges on February 19, 2004. DX 26; DX 30.

Claimant had a formal hearing in Raton, New Mexico on September 26, 2005. Claimant, Employer, and the Director were each represented by counsel. At the hearing, Director's exhibits 1-32, Claimant's exhibits 1-11, and Employer's exhibits 1-7 were admitted into the

[1] All cited regulations are to Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are denoted "DX-"; Claimant's Exhibits are denoted "CX-"; Employer's Exhibits are denoted "EX-". Citations to the hearing transcript are denoted "Tr."

[2] Because the instant claim was filed more than one year from the effective date of the denial of Claimant's previous claim, the claim is treated as a "subsequent claim" under the regulations. § 725.309(d).

record. Tr. 8, 12-13. Employer requested permission to submit a copy of the deposition testimony of Dr. Lawrence Repsher, to be marked as EX 8, after the formal hearing. Neither Claimant nor the Director objected to that request. Tr. 50. The exhibit was received by me on December 6, 2005, and is hereby admitted without objection.

The record was also held open for forty-five days after the parties' receipt of the hearing transcript to allow for the submission of written closing arguments. Tr. 50. An unopposed extension of the due date for filing briefs was thereafter requested by Claimant's counsel, and Claimant and Employer filed their written closing arguments on April 11 and 12, 2006, respectively. No written argument was filed by counsel for the Director, and the record is now closed.

Findings of Fact

A. Coal Miner and Length of Coal Mine Employment

The parties have stipulated, and I find, that Claimant engaged in coal mine employment for at least 20 years (DX 5; DX 8; Tr. 6). Furthermore, I find that any discrepancy in the exact number of years of coal mine employment is inconsequential for the purpose of rendering a decision herein.

B. Date of Filing

Claimant filed his current subsequent claim for benefits under the Act on October 23, 2002. DX 4. There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). No evidence has been offered by Employer to rebut this presumption, and I thus find that the claim was timely filed.

C. Responsible Operator

Employer, Basin Resources, does not contest, and I find, that it is the responsible operator within the meaning of the Black Lung Benefits Act under Subpart G, Part 725 of the Regulations. DX 21, 22.

D. Dependent(s)

Claimant has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Rosabel Martinez Ulibarri. DX 4, 12; Tr. 26.

E. Last Coal Mine Employment

Mr. Ulibarri has described the last coal mine job he performed for a period of a year or more as "utility" or "utilityman." Tr. 27, 39-40. *See also* DX 7 (11/01/89 to 04/15/92; 11/04/92 to 05/12/93; 07/12/93 to 12/31/95); DX 13 (shuttle car operator, rockduster, utility). According to Claimant's testimony, as described further below, "utility" means "the inside labor" and

involves a variety of duties. Tr. 40. In that position, he was required to be available to perform such duties as: hand shoveling coal, hanging ventilation tubing during the time the miners were cutting coal; hauling and loading up to two hundred fifty-pound rock dust sacks per shift; handling up to fifty eighty-pound sacks of concrete during a shift; mixing concrete by hand to build "stoppings" near the mining sections; hauling hydraulic hoses which were "pretty heavy;" moving five-gallon cans and drums of oil and grease by hand; moving fifty-gallon drums of oil; and walking anywhere from one-half mile to a mile in the mines, up and down slopes and through water and mud. Tr. 28-33, 49. *See also* CX 8; DX 13. Although he did not lift 200 sacks of rock dust and 50 sacks of concrete every day, he would do so "[s]ometimes three days a week." Tr. 40. He would go wherever he was assigned, and might be shoveling coal one day and driving a shuttle car the next day. Tr. 49.

Claimant's testimony at the formal hearing was credible and is supported by the other evidence of record in this case. Based on Claimant's testimony and the evidentiary record, I find that Mr. Ulibarri's job as a "utilityman" clearly involved sustained physical labor of a very strenuous nature.

Hearing Testimony

Claimant testified that he completed the eleventh grade and worked as an underground coal miner at the Maxwell, Glen Eagle coal mine in western Colorado from July 20, 1970 until December 31, 1995. Tr. 26. He worked at various jobs including rockduster, mobile driller, roof bolter, brakeman, general inside laborer, timberman, utilityman, and shuttle car operator. Tr. 27; DX 7. He was exposed to coal dust in each of these jobs, most of which were near the face. Tr. 28. He hand-shoveled coal which spilled off the belts when working as a "material man." *Ibid*. He hung ventilation tubing during the time the miners were cutting coal while he was working as a "utility man." Tr. 29. He had to haul rock dust sacks which weighed 50 pounds and load as many as 200 in a shift. Tr. 30. He also had to handle up to 50 sacks of concrete during a shift, each of which weighed 80 pounds. *Ibid*. His duties included mixing concrete by hand to build "stoppings" near the mining sections, hauling hydraulic hoses which were "pretty heavy," and moving five-gallon cans and drums of oil and grease by hand. Tr. 31. He also had to move 50-gallon drums of oil. Tr. 32. He walked anywhere from one-half to a mile in the mines, up and down slopes and through water and mud. *Ibid*.

After Mr. Ulibarri left the coal mine, he worked at a molybdenum mine in Questa. Tr. 33. His job there involved pushing a button to stop the belt carrying rock, tying a cable to a cherry picker, and pressing another button. *Ibid*. His job at the molybdenum mine involved some "heavy physical work." *Ibid*. He also worked another job after leaving the coal mines where he drove a roller machine doing road construction for Chavez Construction Company. *Ibid*. This job did not involve any "heavy work." *Ibid*.

With respect to his respiratory condition, Mr. Ulibarri testified that he used to be able to walk a mile a day, but now he can walk only six or seven blocks after which he has to "go to bed and rest." Tr. 34. He coughs, spits up mucous, and gets dizzy if he over exerts himself. *Ibid*.

He could not perform the physical requirements of his last job as a utility worker in the coal mines because he gets short of breath. *Ibid*.

Mr. Ulibarri's treating physician is Dr. Loretta Conder at the Colfax Medical Center. Tr. 35. He sees her "every few months." *Ibid*. She has prescribed medication for high blood pressure but has never determined that he has anything wrong with his heart. Tr. 36. He saw Dr. Conder after Dr. Repsher examined him and told him he "had a bad heart." Tr. 37. Dr. Conder said there was nothing wrong with his heart. *Ibid*. Claimant smoked two to four cigarettes a day from 1960 to 2002. Tr. 37.

On cross-examination, Mr. Ulibarri stated that he quit working December 31, 1995 because the mine shut down. Tr. 38. The job he was performing at that time was "utility." Tr. 39. He worked shoveling coal onto the belt all day at "the pocket," which is "a big hole where . . . the coal drops down from the top." *Ibid*. "Utility" means "the inside labor" and involves a variety of duties. Tr. 40. He did not lift 200 sacks of rock dust and 50 sacks of concrete every day, but would do so "[s]ometimes three days a week." *Ibid*. He was never "written up" for working too slow. Tr. 41. When he was shoveling coal at the pocket, he would shovel all day except for a 30 minute lunch break. *Ibid*.

Claimant was not exposed to dust when he worked at the molybdenum mine near Questa. Tr. 42. His job involved "putting up tape on the big rocks[,] placing them on the cherry picker and hauling them to the site." *Ibid*. After that, he worked on a construction crew driving the roller. Tr. 43. He did not have any jobs after that because he "couldn't do the labor." *Ibid*. The only exercise he gets is walking six or seven blocks. *Ibid*. He mows the lawn at home which is about 35 feet square. Tr. 44. He runs the vacuum but his wife has to shovel the snow whenever they have any. Tr. 45. In addition to black lung, he has high blood pressure and hepatitis. Tr. 46.

Claimant testified that he worked as a "utility man" for a total of about 10 years. Tr. 49. In that position, he was required to be available to perform any of the duties he previously described. *Ibid*. He might be shoveling coal one day and driving a shuttle car the next day. *Ibid*.

Medical Evidence

Prior Medical Evidence

Because this is a subsequent claim, the evidence submitted in connection with Claimant's two prior claims is part of the record. § 725.309(d)(1). The medical evidence included in the prior claims consists of the following:

Claimant underwent a complete DOL pulmonary evaluation by Dr. David B. Coultas on February 23, 1996 at the Miners' Colfax Medical Center in Raton, New Mexico in connection with his original claim. DX 1. The report of examination reflects complaints by Mr. Ulibarri of wheezing since 1994, and he denied any heart disease or other cardiac problems. Other complaints listed in the report include dyspnea, cough, and paroxysmal nocturnal dyspnea.

Physical examination of the extremities, thorax, lungs, and heart were normal. A chest x-ray reflected Category 1/0 simple pneumoconiosis in the upper lung fields. A pulmonary function study noted the Claimant's age as 50, height as 66" and revealed pre-bronchodilator values of 3.40 for FEV_1, 4.44 FVC, and 157 MVV. An arterial blood gas study reflected pCO_2 values of 32.3 at rest and 29.5 on exercise and pO_2 values of 72.7 at rest and 68.6 on exercise. Dr. Coultas concluded that Mr. Ulibarri had simple coal workers' pneumoconiosis based on the x-ray evidence which resulted in no impairment.

Claimant was next examined on April 24, 2000, again by Dr. Coultas, in connection with his second claim for benefits. DX 2. Dr. Coultas noted similar complaints and physical findings, but this time the pulmonary function study reflected mild airflow obstruction and the arterial blood gas study showed mild hypoxemia at rest. The report of pulmonary function study noted Claimant's age as 55, his height as 66" and reflected pre-bronchodilator values of 2.99 for FEV_1, 4.11 for FVC, and 138 for MVV. The arterial blood gas test reflected pCO_2 values of 30.8 at rest and pO_2 of 58.3 at rest. A chest x-ray taken at the time was read as showing Category 1/1 simple pneumoconiosis with type q/q opacities in the mid and upper lung zones bilaterally and the right lower lung. Dr. Coultas concluded that Claimant had simple coal workers' pneumoconiosis based on the x-ray evidence and that he suffered from a mild respiratory impairment based on evidence of resting hypoxia.

Claimant was examined on July 24, 2000 by Dr. Repsher at Employer's request. DX 2. A July 31, 2000 report of that examination notes, *inter alia*, that Dr. Repsher's findings on physical examination of Claimant were essentially normal except for "a markedly elevated blood pressure of 190/105." A chest x-ray dated January 9, 1999 was interpreted as Category 1/1 simple pneumoconiosis with q/r opacities in both upper and middle lung zones bilaterally and "borderline cardiomegaly." A chest x-ray dated July 24, 2000 was interpreted as showing Category 1/2 simple pneumoconiosis with q/q opacities in the upper, mid, and right lower lung zones with "definite cardiomegaly." Dr. Repsher stated that pulmonary function tests and arterial blood gases were "unequivocally normal." He also noted that a resting electrocardiogram showed no evidence of prior myocardial infarction, ischemia, or chamber hypertrophy. Based on his examination and test results, Dr. Repsher concluded that Claimant had simple coal workers' pneumoconiosis with no pulmonary function impairment. He attributed Mr. Ulibarri's symptoms of "dyspnea on exertion and wheezing at night, as well as cardiomegaly, to untreated hypertension with radiographically apparent target organ damage, that is cardiomegaly."

New Medical Evidence

The medical evidence submitted in connection with Mr. Ulibarri's present claim for benefits includes the following:

Chest X-Ray Evidence[3]

Ex. No.	Physician	B/BCR[4]	Date of X-Ray	Reading
DX 15	James	B	4/25/03	Qual. 1, q/q, 1/2, right and left upper and mid zones.
DX 16	Navani	B/BCR	4/25/03	Quality Reading: 3
CX 11	Repsher	B	11/18/03	Qual. 2, q/r, 1/2, all zones.

A narrative chest x-ray report dated November 18, 2003 and prepared by Michael DeGroot, M.D., notes multiple small nodular densities distributed diffusely throughout the lungs predominantly in mid and upper lung zones. CX 9. The report further notes: "The cardiomediastinal silhouette and pulmonary vasculature are unremarkable." Dr. DeGroot's impression was "could be consistent with coal miner's pneumoconiosis. Less common diagnostic considerations would be miliary tuberculosis, amyloidosis, sarcoidosis and thyroid metastatic disease."

[3] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a), (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease. The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a Category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of Category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is Category 1 opacities but he considered placing the interpretation in Category 2. Similarly, a reading of 0/0 means the doctor found no opacities and did not see any marks that would cause him or her to seriously consider Category 1.

[4] The credentials of interpreters of the x-rays are signified as "B" for a B-reader, "BCR" for a board-certified radiologist, and "B/BCR" for a radiologist who possesses dual qualifications. A physician who is "board-certified" has received certification in radiology by the American Board of Radiology or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(1)(ii)(C). *See Staton v. Norfolk & Western Railway Co*., 65 F.3d 55, 57, 19 BLR 2-271 (6th Cir. 1995). A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Occupational Safety and Health and administered by the U.S. Department of Health and Human Services. See 20 C.F.R. § 718.202(a)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to x-ray readings performed by "B-readers." *See LaBelle Processing Company v. Swarrow*, 72 F.3d 308, 20 BLR 2-76 (3d Cir. 1995). An administrative law judge may properly defer to the readings of the physicians who are both B-readers and Board-certified radiologists. Roberts v. Bethlehem Mines Corp., 8 BLR 1-211 (1985). *See Zeigler Coal Co. v. Director, OWCP [Hawker]*, 326 F.3d 894, 899 (7th Cir. 2003). Finally, a radiologist's academic teaching credentials are relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See Worhach v. Director, OWCP*, 17 BLR 1-105 (1993).

Pulmonary Function Tests[5]

Ex. No.	Physician	Date of Study	Age	Height[6]	Qual.	FEV_1	FVC	MVV
DX 14	James	4/25/03	57	66"	No	2.50 2.96	3.29 3.67	76 81
EX 4	McClung	11/18/03	58	67"	No	2.67 2.69	3.34 3.36	-- --
CX 3	Maier	1/19/05	59	170 cm[7]	No	2.54 1.94	3.14 2.52	-- --

Blood Gas Studies[8]

Ex. No.	Physician	Date of Study	Resting(R) Exercise(E)	Altitude	$p0_2$	pCO_2	Qualifying?
DX 13	James	4/25/03	R	6000	66.8	37.6	No
			E		63.4	32.1	No
EX 5	Repsher	11/18/03	R	3,000 –	67	36	No
			E	5,999	--	--	--
CX 3	Rose	1/20/05	R	3,000 –	74	30	No
			E	5,999	67	34	No

Physician's Opinions

Dr. David S. James

Dr. James performed an examination of Claimant on behalf of the Department of Labor on April 25, 2003. DX 12. He noted a history of 21 1/4 years of underground coal mine employment with the last two years involving heavy lifting as a materials man. He noted a smoking history of 4 cigarettes daily from 1960 to 2002 resulting in an 8 pack year smoking history. Symptoms on physical examination included productive cough, wheeze, and dyspnea.

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[5] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in "substantial compliance" with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 BLR 1-27 (1988). The values from the FEV_1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability. Where two values are indicated, the first represents the value before broncodilation and the second is the result after dilation. If only one set of numbers appears, no values were recorded post-dilation.

[6] The height is indicated as recorded by each physician. The ALJ is required to resolve the height discrepancies contained in the record. *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). Since two of the reported heights (rounded to the nearest hundredth) were recorded as 67 inches, this height is adopted for purposes of this decision.

[7] 170 cm is equal to 66.93 inches.

[8] Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).

Dr. James also noted a history of high blood pressure with no history of heart disease. Based on the Claimant's more than 20 year history of coal dust exposure, symptoms on physical examination, and positive chest x-ray, Dr. James diagnosed, *inter alia*, coal workers' pneumoconiosis and history of hypertension. He further concluded that Mr. Ulibarri was totally disabled from a respiratory standpoint from returning to work as a coal miner. Dr. James wrote:

> Mr. Ulibarri's chest x-ray shows mild to moderate radiographic changes. His resting arterial blood gas is normal and he has a mild decrease with maximum exercise. His maximum exercise tolerance is mildly decreased. It was directly measured using a metabolic cart and his oxygen consumption at maximum exercise was 20.6 ml/kg/minute. Given the very strenuous physical demands of his work, as outlined, while he was a materials person at the coal mine, with a reasonable degree of medical certainty, Mr. Ulibarri is totally disabled from his respiratory disease, coal workers' pneumoconiosis, and is totally disabled as a coal miner.

Ibid.

Dr. James subsequently reviewed various documents relevant to this case at Claimant's request. CX 4. According to his August 30, 2005 report, Dr. James reviewed: letters dated July 26, 2005, December 10, 2003, and July 31, 2000 from Dr. Repsher; a consultation report by Dr. Rose and objective test results obtained by her on January 20, 2005; and a list of the requirements of Claimant's last coal mining job dated July 6, 2005. Dr. James notes preliminarily that coal workers' pneumoconiosis may progress even after cessation of coal mine dust exposure. Based on his review of the additional evidence, as well as the results of his examination on behalf of DOL, he further wrote:

> Mr. Ulibarri has evidence of respiratory impairment identified on my evaluation of Mr. Ulibarri from April 25, 2003. Mr. Ulibarri's oxygen level with activity declined. The arterial oxygen level with activity typically either stays the same or increases. On the evaluation of Mr. Ulibarri by Dr. Rose on January 20, 2005, a decline in arterial oxygen level with activity was also documented. With a reasonable degree of medical certainty, Mr. Ulibarri's coal workers' pneumoconiosis is a contributing factor in the decline in arterial oxygen with activity.

Id. at 1. Dr. James also noted that the cardiac stress test performed by him on April 27, 2003 did not show evidence of cardiac limitation, the ECG revealed no significant changes, an adequate cardiac stress was performed based on a heart rate of 100% of predicted, and fatigue was the reason for stopping the study. *Id.* at 2. According to Dr. James, "Mr. Ulibarri's symptoms of shortness of breath with exertion are related to his coal workers' pneumoconiosis and the decline in arterial oxygen levels." *Ibid*. He further noted Claimant had no history of coronary artery disease or congestive heart failure and there were no other likely cardiac or respiratory disorders to explain his symptoms. With respect to the pulmonary function study performed by Dr. Rose on January 19, 2005, Dr. James noted that "the decline in lung function post-bronchodilators can occur in individuals who become fatigued from performing the maneuver." *Ibid*. In summary,

he wrote that Claimant had coal workers' pneumoconiosis with "evidence of respiratory impairment on arterial blood gas studies with exercise that is a contributing factor in his diminished exercise capacity, and because of the strenuous nature of his last coal mine employment, he would be unable to perform his usual coal mine job due to his respiratory impairment." *Ibid*.

According to his curriculum vitae, Dr. James is board-certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine, and he is a NIOSH certified B-reader. CX 5. He obtained a Bachelor of Science degree from Colorado State University in 1980, a Master of Science degree from Colorado State University in 1982, and a Medical Doctorate degree from the University of Colorado School of Medicine in 1986. He has taught as an Associate Professor of Medicine at the University of New Mexico School of Medicine, published various articles including papers related to western coal miners, and presently works as a staff physician at Four Corners Pulmonary and Critical Care Medicine and Mercy Medical Center in Durango, Colorado.

Dr. Lawrence Repsher

According to a December 10, 2003 letter, Dr. Repsher examined Claimant on November 18, 2003 at St. Mary Corwin Hospital in Pueblo, Colorado at Employer's request. EX 2. He noted relevant work, medical, smoking, and family histories, and recorded current complaints of progressive dyspnea on exertion, especially at night, as well as coughing at night with occasional sputum production. *Id.* at 1-2. His physical examination was essentially normal except for an elevated blood pressure. *Id.* at 2. A July 2002 chest x-ray revealed evidence of probably mild simple coal workers' pneumoconiosis with no evidence of complicated coal workers' pneumoconiosis. *Ibid*. A CT scan similarly showed simple coal workers' pneumoconiosis. *Id.* at 3. Pulmonary function testing was "unequivocally normal, including a normal diffusing capacity, which would rule out any clinically significant interstitial lung disease, such as coal workers' pneumoconiosis." *Ibid*. Arterial blood gases were normal for age and altitude, and carboxyhemoglobin level was normal. *Ibid*. An echocardiogram was interpreted by Dr. Repsher as showing "diastolic dysfunction and very mild pulmonary hypertension of no present clinical significance." *Ibid*. Based on his examination and the clinical data, Dr. Repsher diagnosed mild simple coal workers' pneumoconiosis, hypertension complicated by diastolic dysfunction, and no evidence of any other pulmonary or respiratory disease or condition, either caused by or aggravated by Claimant's employment as a coal miner. *Ibid*. It was Dr. Repsher's opinion that Mr. Ulibarri's coal workers' pneumoconiosis resulted in no "impairment or disability, either caused by or aggravated by his employment with Basin Resources as an underground coal miner." *Ibid*. He based that opinion on the lack of x-ray evidence of complicated coal workers' pneumoconiosis, normal pulmonary function and diffusing capacity, normal arterial blood gases, and symptoms of dyspnea on exertion "adequately explained by his documented diastolic dysfunction, as the result of hypertensive cardiovascular disease." *Ibid*.

In a letter dated July 26, 2005, Dr. Repsher noted that he had reviewed additional medical evidence and other records relating to Claimant, including the report and clinical evidence produced by Dr. Rose after her evaluation of Claimant on January 20, 2005. EX 1. He disagreed with Dr. Rose's conclusion that Claimant's worsening black lung was consistent with published

medical studies showing that coal workers' pneumoconiosis is often progressive and disabling, noting that the U.S. Court of Appeals in Washington, D.C. had ruled that "CWP is only rarely progressive." *Id.* at 1. Dr. Repsher also disagreed that Mr. Ulibarri had progressive coal workers' pneumoconiosis and was totally disabled from performing his usual coal mine job. *Ibid*. He stated that Claimant's November 2003 pulmonary function tests were "unequivocally normal, including a normal diffusing capacity, which would rule out any clinically significant interstitial lung disease, such as coal workers' pneumoconiosis." *Ibid*. He further noted that the most recent study done in 2005 was "uninterpretable, due to extremely poor effort and cooperation with the testing on the part of Mr. Ulibarri." *Ibid*. Dr. Repsher described the April 25, 2003 treadmill stress test performed by Dr. James as "grossly incomplete," but stated that it "actually documents that Mr. Ulibarri was clearly limited by his heart function and not limited all [sic] by his lung function, which is not surprising in view of the fact that he clearly had normal pulmonary function by testing." *Id.* at 2. According to Dr. Repsher, Claimant had passed his anaerobic threshold by the time he stopped exercising due to fatigue, and individuals with limited lung function generally cannot even reach their anaerobic threshold. *Ibid*. Dr. Repsher thus concluded that Claimant's symptoms of dyspnea on exertion "are more than adequately explained by his documented diastolic dysfunction, as a result of hypertensive cardiovascular disease." *Ibid*. His impressions and opinions from his earlier report thus remained unchanged.

Dr. Repsher's curriculum vitae shows that he received a Bachelor of Arts degree from Harvard College in 1961, a Medical Doctorate degree from Rochester School of Medicine & Dentistry in 1965, and is board-certified in, *inter alia*, Internal Medicine, Pulmonary Disease, and Critical Care Medicine. EX 6. He has also been a NIOSH B-reader since 1981, and is presently Medical Director of the Occupational & Environmental Lung Disease Program at the Lutheran Medical Center in Wheat Ridge, Colorado. *Ibid*. Dr. Repsher is widely published and has authored various articles and papers on the assessment and treatment of pulmonary diseases including chronic obstructive pulmonary disease and pneumoconiosis.

Dr. Repsher was deposed by Employer's counsel on August 22, 2005 with respect to his opinions in this case. EX 8. He noted that he examined Claimant twice, once in 2000 and again in 2003, and that he reviewed the available records, obtained a history emphasizing occupational/environment factors, did a physical exam emphasizing the heart and lungs, and ordered various clinical tests. *Id.* at 5-6. Based on the chest x-ray, Dr. Repsher diagnosed simple coal workers' pneumoconiosis but saw no evidence of pulmonary impairment or disability. *Id.* at 6-7. He also determined that Mr. Ulibarri had high blood pressure, which was poorly controlled by medication and complicated by diastolic dysfunction. *Id.* at 7. Dr. Repsher concluded that lung function was "entirely normal" based on pulmonary function testing, and blood gas test results were normal for Claimant's age and the altitude at which the test was administered. *Ibid*. The results of both tests did not meet the DOL standards for disability. *Id.* at 8. The results of the 2005 pulmonary function test administered by Dr. Rose were normal prebronchodilator and uninterpretable post-bronchodilator due to poor effort by Claimant. *Ibid*. The use of a bronchodilator should have no effect or should improve pulmonary function, and in Mr. Ulibarri's case the pulmonary function decreased post-bronchodilator. *Id.* at 9.

With respect to his opinion on disability, Dr. Repsher testified that Claimant was "certainly not disabled as a result of a lung problem or a pulmonary problem." *Id.* at 10. He

did, according to Dr. Repsher, have hypertensive cardiovascular disease with diastolic dysfunction, and the exercise test previously administered by Dr. James "clearly shows that Mr. Ulibarri's ability to exercise was limited by his heart function and not limited at all by his lung function." *Ibid*. Dr. Repsher reached this conclusion based on the fact that people who are limited by their lung function cannot reach their anaerobic threshold, as Mr. Ulibarri did, and because Claimant "was markedly hypertensive at rest and with exercise, which goes along with his hypertensive cardiovascular disease." *Ibid*. None of Claimants other physical ailments would contribute to Mr. Ulibarri's present condition in Dr. Repsher's opinion. *Id.* at 11. He further testified that even if Claimant were totally disabled, his simple pneumoconiosis would not be a contributing cause of disability since "[c]oal miners who have Category 0/0 to 3/3 pneumoconiosis on the average have normal lung function." *Id.* at 14. According to Dr. Repsher, it was not significant that Mr. Ulibarri's pulmonary function test results between February 1996 and January 2005 had been on a "slow to steady decline." *Id.* at 14-15. Despite the fact that the difference was "much greater than you would expect just from aging alone," Dr. Repsher stated:

> But when you look at the most recent pulmonary function test, there is just a gross lack of effort and cooperation with the testing and that those tests are medically invalid for interpretation for the presence of any intrinsic lung or pulmonary disease."

Id. at 15. Dr. Repsher further testified that, although an April 2000 arterial blood gas study showed levels which were "technically under the Department of Labor standard [for disability]," subsequent tests revealed results which were not reflective of disability. *Id.* at 17-18. The 2000 results, according to Dr. Repsher, were likely the result of a faulty test which mixed venous blood with arterial blood causing a lower pO_2 reading. *Id.* at 18.

Dr. Repsher also testified that his 2000 examination of Claimant revealed evidence of cardiomegaly, *i.e.*, an enlarged heart. *Id.* at 19. However, he concluded that Claimant's pulmonary function was normal and that he "would have the respiratory capacity to do not only his own job in the mine but any other job, even – when it required sustained heavy exertion . . . ." *Id.* at 20. He went on to state, however, that Claimant's hypertensive cardiovascular disease would probably not allow Claimant to perform sustained heavy exertion, but further stated that such disease "has nothing to do with his lungs." *Ibid*.

On cross-examination, Dr. Repsher testified about his familiarity with the various jobs performed by Claimant during his 20 years of underground coal mine employment and agreed that his exposure to coal mine dust during that period was sufficient to cause pneumoconiosis. *Id.* at 22-25. He further agreed that the x-ray evidence possibly showed an increase in the number and location of opacities on Claimant's chest x-rays. *Id.* at 26-29. He also agreed that miners who drill into hard rock, such as roof bolters, are exposed to higher concentrations of silica and are at higher risk for developing silicosis as a result of their coal mine dust exposure. *Id.* at 38. He similarly agreed that a decrease in pO_2, also referred to as exercise desaturation, can be related to coal-mine-dust-related lung disease, but stated that there are also many other causes, most commonly heart disease, for that result as well. *Id.* at 39. Dr. Repsher further testified that it is possible, but unlikely that a decrease in pO_2 with exercise can be related to

simple coal workers' pneumoconiosis. *Ibid*. He also testified that individuals with Category 0/0 to 3/3 simple coal workers' pneumoconiosis "on average" have normal diffusing capacities. *Ibid*. In apparent contradiction, however, he testified: "[I]t would be possibly [sic] for a miner to have impairment of the diffusing capacity. In fact, statistically, it would be almost a certainty." *Ibid*. Dr. Repsher stated that it was possible, but unlikely, that someone with Category 1/1 or 1/2 pneumoconiosis would have shortness of breath on exertion. *Id.* at 39-40.

According to Dr. Repsher, he did not perform exercise arterial blood gas studies on Mr. Ulibarri in July 2000 and November 2003 because "it was contraindicated because he had significant underlying heart disease and, according to the Department of Labor regulations, one does not do an exercise blood gas under those circumstances." *Id.* at 40. He also stated that an echocardiogram was "hardly a comprehensive evaluation of the heart." *Id.* at 41. Thus, according to Dr. Repsher, the echocardiogram performed by Dr. James "hardly rules out heart disease because he only had one very simple test." *Ibid*. He acknowledged that his own report of examination from July 2000 noted that Claimant's heart and extremities were normal on physical examination with no signs of edema or abnormal heart sounds. *Id.* at 41-42. The results of his November 2003 examination were similarly "normal" although an echocardiogram reflected that the "diastolic function is reduced . . . ." *Id.* at 42-43.

On re-direct examination, Dr. Repsher testified that he could not rule out the possibility that Claimant is suffering from a progressive strain of simple coal workers' pneumoconiosis, but he also stated that the change in profusion "of one box is not significant." *Id.* at 47. In Dr. Repsher's opinion, even if Claimant's pneumoconiosis was progressive, he had no "impairment or disability as a result of that." *Ibid*.

Dr. Repsher also testified that he disagreed with Dr. DeGroot's interpretation of the November 18, 2003 chest x-ray inasmuch as Dr. DeGroot made no mention of an enlarged heart and described the cardiomediastinal silhouette and pulmonary vascularity as "unremarkable," while Dr. Repsher interpreted the x-ray as showing an enlarged heart. *Id.* at 53. Dr. Repsher had no opinion on the CT scan obtained at that time and stated:

> [The heart is] enlarged on chest x-ray and he has diastolic dysfunction by echocardiogram and he has inadequately treated, severe hypertension. That all fits together and clearly documents that he is suffering from hypertensive cardiovascular disease.

Id. at 53-54.

Dr. Cecile S. Rose

Dr. Rose examined Claimant at the National Jewish Medical and Research Center in Denver, Colorado on January 20, 2005. CX 1. She noted under "History of Present Illness" that Claimant reported shortness of breath beginning in 1994 which was worse when he was around rock dust. She further noted that he had been examined by Dr. Coultas, a pulmonologist, "who did testing and told him he had Black Lung." *Id.* at 1. According to Dr. Rose, Claimant was also evaluated in 1996 by Dr. Wagner in Raton, New Mexico, again told he had Black Lung, and

continued to be followed by Drs. Wagner and Conder. *Ibid*. An examination in 2000 further confirmed that Mr. Ulibarri had "Black Lung with associated disability." *Id.* at 2. Dr. Rose also noted that Dr. Repsher concurred that Claimant had "Black Lung/silicosis." *Ibid*. Finally, Dr. Rose noted that Dr. James saw Claimant "for follow-up in 2002, and was again told that he was 'disabled from the coal mine'." *Ibid*.

Dr. Rose listed Claimant's current symptoms as shortness of breath while walking on level ground and on hills, wheezing and whistling in his throat associated with postnasal drainage, productive cough worse at night with yellow and occasionally black sputum, and restless sleep. *Id.* at 2. Past medical history is recorded as occupational black lung diagnosed in 1995, hypertension, hepatitis A diagnosed in 2004, seasonal allergies, goiter diagnosed 10-12 years ago, and dyslipidemia. *Ibid*. Claimant's medical, social, and environmental/occupational histories were recorded, and Dr. Rose further noted, with respect to respiratory symptoms, that Mr. Ulibarri reported shortness of breath with activity, productive cough worse at night with about three teaspoons of black or yellow sputum per night, associated wheezing, chest tightness, and stridor. *Id*. at 2-4. Her physical findings included, *inter alia*, relaxed, symmetrical respiratory effort, lungs clear to ausculation and percussion, and no costovertebral angle tenderness with respect to the respiratory system. *Id.* at 5.

In addition to conducting her examination of Mr. Ulibarri, Dr. Rose also reviewed various objective test results from St. Mary Corwin Hospital including a CT scan of the chest, a complete pulmonary function test, and an echocardiogram, all from November 18, 2003, and an arterial blood gas test done on December 2, 2003. *Id.* at 5-6. In addition, she described the previously-referenced reports of Drs. Repsher and James. *Id.* at 5-7.

With respect to test results obtained during Dr. Rose's January 20, 2005 examination, she noted that a CT scan revealed '[i]nnumerable small nodular opacities measuring 2-5 mm in diameter . . . throughout the lungs, but predominating in the upper and mid lung zones." *Id.* at 8. The nodular opacities had increased in number since the prior 2003 study. *Ibid*. She further recorded that "[t]he heart size is normal." *Ibid*. Her impression from this study was innumerable parenchymal nodules which "are most suggestive of silicosis." *Ibid*. Dr. Rose further recorded the results of a pulmonary function test and arterial blood gas study done at the time of her examination. *Id.* at 8. Based on her review of all the evidence, she noted impressions of *inter alia*:

> 1. Black Lung disease/coal worker's pneumoconiosis, with approximately 20 years of occupational underground coal mine dust exposure, worsening symptoms of exertional dyspnea and productive cough, radiographic evidence of increasing profusion of upper lobe pneumoconiotic nodules and worsening pulmonary function.
> . . . .
> 5. Hypertension, treated, though not well-controlled at this evaluation as patient did not take his medication.
> 6. Ex-smoker for four years, with mild previous smoking history (approximately 4 pack-years).
> . . . .

Id. at 9. She further wrote that "[w]hile arterial blood gases do not show hypoxemia, there is a greater than expected decrease in PaO_2 with exertion . . . [showing] that Mr. Ulibarri is impaired from performing the strenuous tasks of his last usual coal mine job as a utility man, requiring significant lifting, carrying, loading and walking as previously described." *Ibid*. She thus concluded that Claimant was totally disabled and that coal workers' pneumoconiosis was a substantially contributing cause of his disability. *Id.* at 10.

According to her curriculum vitae, Dr. Rose received her undergraduate degree from Northwestern University in Evanston, Illinois in 1976, and her medical degree from the University of Illinois School of Medicine in 1980. CX 2. She is board-certified in Internal Medicine, Pulmonary Medicine, and General Preventive/Occupational Medicine, and is a NIOSH certified B-reader. *Id.* at 2. She is presently employed as an associate professor at the University of Colorado School of Medicine in the Departments of Medicine (Pulmonary Division) and Preventive Medicine and Biometrics, and is also the Director of the Occupational Medicine Clinical Program at the National Jewish Medical and Research Center in Denver, Colorado. *Id.* at 1. She previously taught at the Medical College of Virginia and has published numerous works on, *inter alia*, respiratory diseases. *Id.* at 2, 12-17.

Dr. Rose was deposed by Claimant's counsel on September 9, 2005. CX 7. She testified that she has been on the staff of National Jewish Hospital for 17 years and is, *inter alia*, director of the occupational and environmental lung disease clinic there as well as medical director of the Miners Clinic of Colorado at the hospital. *Id.* at 5-6. She described the Miners Clinic of Colorado as

> a federally funded clinic targeted at miners in the state of Colorado for medical surveillance and assistance with diseases associated with mining exposures, such as lung diseases, hearing loss, and other respiratory disease.

Id. at 5. She further testified:

> National Jewish has been in existence for over a hundred years here in Denver. It's proud of its status as the number one respiratory hospital in the United States. It focuses mainly on respiratory, allergic, and immunologic diseases. National Jewish has very active clinical programs. We're very involved in teaching, and there's also a great deal of research, both clinical research and laboratory-based research, that occurs here.

Id. at 5-6. Dr. Rose has evaluated and treated coal miners for respiratory diseases throughout her 17 years at National Jewish Hospital, but even more so during the three years she has been Director of the Miners Clinic of Colorado. *Id.* at 8. The clinic has evaluated over 500 miners over the past three years, and a conservative estimate of the number of coal miners included in that group is 200. *Id.* at 9.

Dr. Rose performed a complete pulmonary evaluation of Claimant on January 20, 2005, which included obtaining relevant histories, conducting a review of Mr. Ulibarri's systems,

performing a physical examination, and conducting an evaluation of clinical test results. *Id.* at 9-10. She noted that Dr. James had recorded a smoking history of 4 cigarettes per day between 1960 and 2002, which would equate to an eight-pack-year history, while Claimant reported to her that he smoked approximately four cigarettes per day for about 20 years, which would equate to a four-pack-year history. *Id.* at 13-14. Neither smoking history, in Dr. Rose's view, was significant with respect to her conclusions in this case, including her opinion that Claimant's cigarette smoking did not play a significant role in his current respiratory disease. *Id.* at 14. She described Claimant's last coal mine job as a "utility man" as "extremely strenuous." *Id.* at 16.

With respect to her examination, Dr. Rose testified that she found no evidence of any abnormalities indicative of heart disease. *Id.* at 17. The high-resolution CT scan obtained at that time revealed findings suggesting silicosis in combination with coal workers' pneumoconiosis. *Id.* at 18. Claimant's pulmonary function test indicated a mild degree of airflow decrease prior to bronchodilator and moderate reduction in diffusion capacity. *Id.* at 19. According to Dr. Rose:

> The reduction in diffusion capacity reflects a decrease in the ability of the lung to perform its major function, which is gas exchange, so it reflects the decrease in the lung's ability to allow oxygen to diffuse across from the lung into the blood capillaries to be then distributed to the vital organs.

Ibid. The PFT values represented respiratory impairment. *Id.* at 20. Similarly, Claimant's arterial blood gas study revealed a drop in oxygen tension after exercise indicating an impairment of gas exchange. *Ibid*. When asked if that result indicated a significant respiratory impairment, Dr. Rose testified:

> In the context of Mr. Ulibarri, it does, in that he was required to perform very strenuous labor when he was working as a miner, and this abnormal decline and increase in hypoxemia with exercise would impair his ability to perform these very strenuous tasks as a coal miner.

Ibid. Dr. Rose's blood gas test results in 2005 showed almost double the decline in oxygen tension after exercise shown on Dr. James' study in 2003, *i.e.*, 7 mm of mercury difference versus 3.4 mm of mercury difference, although some of that difference could be accounted for by the higher elevation in Raton, N.M. where Dr. James' study was done. *Id.* at 21-22. There was no evidence of any heart disease in Dr. James' examination, and the ECG he administered was normal. *Id.* at 22-23.

Dr. Rose diagnosed coal workers' pneumoconiosis due to 20 years employment as an underground coal miner that had worsened since his initial evaluation for black lung. *Id.* at 23-24. When asked to explain her diagnosis, she testified:

> The basis for my diagnosis included the following. The first was his occupational history. The second was his symptom history. The third was the rest of the historical components that are relevant in understanding the cause of someone's

> shortness of breath, cough, and sputum production. The fourth was the findings on physical examination. The fifth was the pulmonary function testing. The sixth was the results of arterial blood gas testing at rest and with exercise. And the seventh and very important component was the imaging findings on high-resolution CT scan.

Id. at 24. Dr. Rose further testified:

> Moreover, Mr. Ulibarri reports worsening of his respiratory symptoms over time, and that symptomatic worsening is supported by the clinical findings that show that his imaging, his CT scan and his chest x-rays, have clearly worsened over time since his initial evaluation, the fact that his pulmonary function testing has worsened over time, and the fact that his arterial blood gases have showed a more profound decline in oxygen tension over time.

Id. at 25. According to Dr. Rose, the oxygen desaturation on exercise is a result of an increasing profusion of pneumoconiotic opacities combined with a decline in his pulmonary function, *i.e.*, "the profusion of macules and nodules has impaired his lung's ability to meet the oxygen demands of exercise." *Id.* at 25-26. Dr. Rose also stated that Claimant's other symptoms, including his reduced diffusion capacity, shortness of breath on exertion, cough, and sputum production, were causally related to his coal mine dust-induced respiratory disease inasmuch as those symptoms "are all classic symptoms for coal workers' pneumoconiosis and/or silicosis, especially in the context of obvious worsening of that disease over time." *Id.* at 26-27.

Dr. Rose found no evidence of heart disease based on her examination and test results, although she testified that Claimant does have hypertension which is a risk factor for heart disease. *Id.* at 27. Based on her review of all the medical evidence, she concluded:

> There is no evidence to support a diagnosis of cardiomyopathy or congestive heart failure in Mr. Ulibarri. I believe he did have a fleck of calcium in a coronary artery on a CT scan, which is a common finding, particularly in older men, but other than that, he had no evidence for cardiomyopathy or congestive heart failure whatsoever.

Id. at 28.

Dr. Rose disagreed with Dr. Repsher's opinion that Mr. Ulibarri's shortness of breath on exertion was adequately explained by heart disease, described by Dr. Repsher as diastolic dysfunction resulting from hypertensive cardiovascular disease. *Ibid*. Dr. Rose explained that the echocardiogram upon which Dr. Repsher relied showed a left ventricle which was normal in size and systolic function, no decrease in the left ventricular ejection fraction, and "very little . . . to support any evidence for diastolic heart failure or any evidence for cardiomyopathy." *Id.* at 30. Furthermore, according to Dr. Rose, the issue of diastolic dysfunction is highly controversial among cardiologists inasmuch as there is disagreement over how to define it and whether it is even clinically relevant. *Ibid*. She testified that even if you assume Claimant's echocardiogram results revealed evidence of "a very early or very mild category of diastolic dysfunction, . . . it

would in no way explain Mr. Ulibarri's respiratory symptoms, nor the findings on his high-resolution CT scan, nor would it explain his pulmonary function abnormalities or the decline in oxygen tension with his arterial blood gas testing, so the bottom line is this is a complete red herring, and has no relevance at all in terms of understanding or explaining Mr. Ulibarri's clinical findings." *Id.* at 31.

Dr. Rose also disagreed with Dr. Repsher's opinion that, since Claimant reached his anaerobic threshold on exercise when tested by Dr. James, his exercise stress test results in 2003 must have been limited by his heart function and not his lung function. *Id.* at 31. According to Dr. Rose:

> The anaerobic threshold by itself cannot be used to distinguish why a person has an exercise limitation. There are many reasons for that, and he clearly didn't exercise to maximum capacity, anyway, and he has a fall in his exercise tension.
>
> This is just an effort, I believe, to obfuscate and to take away from the very simple facts of this case, which is that Mr. Ulibarri has progressive coal workers' pneumoconiosis, and that explains his shortness of breath, his functional abnormalities, his worsening CT abnormalities, and his decline in oxygen tension.

Id. at 32. She further testified that a person can achieve a maximum heart rate and still have respiratory impairment. *Id.* at 33.

Dr. Rose agreed that pneumoconiosis is a latent progressive disease, and she was familiar with, and agreed with, the Department of Labor's comments regarding the medical literature summarized in the Federal Register in support of the revised black lung regulations. *Id.* at 35. She testified:

> Well, I've read the Federal Register pertinent to black lung, because it has an outstanding summary of the medical literature regarding the respiratory health effects from exposure to coal mine dust, so I'm quite familiar with the Federal Register as it pertains to the summary of the medical literature and also to the criteria that are used to evaluate people for black lung benefits.

Id. at 37-38.

With respect to Dr. Repsher's conclusion that the pulmonary function test results obtained by Dr. Rose in January 2005 were "uninterpretable due to poor effort and cooperation," Dr. Rose testified that Claimant's decline in his forced vital capacity and his FEV_1 occurred after a bronchodilator was used. *Id.* at 42. She further testified that some individuals suffer a reaction to the propellant used in the bronchodilator which may trigger upper airway dysfunction and lead to questionable results and this phenomenon could explain Mr. Ulibarri's results. *Ibid*. Dr. Rose went on to state, however, that the results of the test prior to the administration of the bronchodilator were unquestionably valid, as shown by the flow volume curves contained in the pulmonary function testing, and those results indicated a decline in his lung function that

mirrored the increased perfusion of nodules seen on his CT scan which were associated with his worsening gas exchange and other symptoms. *Id.* at 42-43.

Dr. Rose acknowledged on cross-examination that Claimant had "a number of other medical problems besides his coal workers' pneumoconiosis." *Id.* at 45. These included hypertension, obstructive sleep apnea, possible depression, and dyslipidemia (high cholesterol). *Id.* at 45-46. Hypertension and dyslipidemia are both risk factors for heart disease. *Id.* at 46.

When asked if she disagreed with the statement that "Latent and progressive pneumoconiosis is rare, occurring in a small percentage of cases, . . . " Dr. Rose testified that use of the term "rare" was problematic. *Id.* at 50-51. Although she agreed that progressive coal workers' pneumoconiosis was "rare" in the context of the general population, she would disagree with that characterization if it was applied to people who have many years of exposure to coal mine dust, particularly those performing tasks such as roof bolting which typically involve a very high degree of exposure to respirable quartz that can cause silicosis. *Id.* at 51. Under those circumstances, she testified, it would not be "rare" to have progression of pneumoconiosis. *Ibid*.

Dr. Rose acknowledged that she was generally familiar with the Department of Labor's standards for disability with respect to arterial blood gases and that neither the resting nor the exercise blood gas results for Mr. Ulibarri were qualifying. *Id.* at 53-55. She further agreed that pulmonary function test results are effort-dependant, that the post-bronchodilator results in the 2005 study were uninterpretable, and that the pre-bronchodilator results of the test were non-qualifying. *Id.* at 55.

Discussion and Conclusions of Law

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *See Gee v. W.G. Moore & Sons,* 9 B.L.R. 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988); *aff'd*, 865 F.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606

(1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge to determine. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Where, as here, a claimant has filed more than one claim and the earlier claim was denied, the later claim must also be denied on the grounds of the earlier denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d). Since Claimant failed to establish total disability due to pneumoconiosis in the prior denial, the evidence will be reviewed to determine if Claimant has now established that that condition of entitlement has changed since the prior denial of August 23, 2000.

Totally Disability Due to Pneumoconiosis

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. 20 C.F.R. § 718.204(b)(1). If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish the claimant's total disability. According to Section 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies; 2) arterial blood gas tests; 3) a cor pulmonale diagnosis; and 4) a reasoned medical opinion concluding total disability.

In the present case, Claimant does not have any qualifying pulmonary function studies or arterial blood gas tests and there is no evidence of cor pulmonale with right-sided congestive heart failure. He thus cannot establish total disability pursuant to §§ 718.204(b)(2)(i), (ii) or (iii). However, for the reasons stated below, I find that Claimant has established total disability based on the reasoned medical opinion evidence pursuant to § 718.204(b)(2)(iv).

Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination, constitute adequately documented medical opinions as contemplated by the regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation

supports its conclusions, an administrative law judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983). However, a physician's medical opinion may not be rejected simply because the physician relies on pulmonary function or arterial blood gas studies which render nonqualifying results. *See, e.g.*, *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 577 (6th Cir. 2000) (inappropriate for ALJ to reject physician's opinion because physician relied on pulmonary function study which yielded numbers above those establishing disability).

In assessing total disability under 20 C.F.R. §718.204(b)(2)(iv), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000) (a finding of total disability may be made by a physician who compares the exertional requirements of the miner's usual coal mine employment against his physical limitations); *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993) (a qualified opinion regarding the miner's disability may be given less weight). *See also Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(en banc on recon.).

Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to 20 C.F.R. §718.204(c)(2) (2000) or 20 C.F.R. §718.204(b)(1)(ii) (2001). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The Tenth Circuit requires that the pneumoconiosis be "at least *a contributing cause*" of the miner's disability. *Mangus v. Director, OWCP*, 882 F.2d 1527, 1531 (10th Cir. 1989) (emphasis added).

As noted previously, Dr. James concluded, after examining Mr. Ulibarri on behalf of DOL, that Claimant could not perform his last job as a coal miner because of his respiratory impairment. DX 12. Symptoms on physical examination recorded by Dr. James during the examination included productive cough, wheeze, and dyspnea. Dr. James also noted that, while the Miner's arterial blood gas test results were normal at rest, the test revealed a "mild decrease with maximum exercise." Based on his examination, Dr. James concluded: "Given the very strenuous physical demands of his work, as outlined, while he was a materials person at the coal mine, with a reasonable degree of medical certainty, Mr. Ulibarri is totally disabled from his respiratory disease, coal workers' pneumoconiosis, and is totally disabled as a coal miner." *Id.* at 2.[9]

At Claimant's request, Dr. James reviewed additional medical evidence relevant to the issue of whether the Miner was disabled as a result of his 20 years of coal mine employment and reported the results of his review in a letter dated August 30, 2005. CX 3. Evidence reviewed by

[9] DX 13 is an eight-page exhibit which includes, *inter alia*, the standard four-page DOL Form CM-988 "Medical History and Examination for Coal Mine Workers' Pneumoconiosis" plus a two-page narrative medical report by Dr. James. The page reference cited above refers to the second page of this narrative report.

Dr. James included: three medical reports by Dr. Repsher dated July 31, 2000, December 10, 2003, and July 26, 2005; the medical report prepared by Dr. Rose regarding her examination of Claimant on January 20, 2005, including the results of clinical tests performed at that time; and a description of the requirements of Mr. Ulibarri's last coal mining job. Based on his review of this evidence and the results of his prior examination, Dr. James concluded that Claimant's coal workers' pneumoconiosis was a contributing factor in causing the decline in arterial oxygen with activity reflected in the arterial blood gas studies performed by him and Dr. Rose. He further noted that Mr. Ulibarri's symptoms of shortness of breath with exertion were also related to Claimant's coal workers' pneumoconiosis. Dr. James also noted that Claimant had no history of coronary artery disease or congestive heart failure and stated that the cardiac stress test he performed during the DOL examination "did not show evidence of cardiac limitation." He wrote:

> The ECG was without significant change. The heart rate of 100% of predicted indicated that an adequate cardiac stress was performed. Fatigue was the indication for stopping the study. This is a relatively nonspecific finding that can be present in a number of different conditions that would limit exercise.

Id. at 2. Dr. James thus concluded that Mr. Ulibarri's shortness of breath and decline in arterial oxygen levels were related to his coal workers' pneumoconiosis since "[t]here are no other likely cardiac or respiratory disorders to explain his symptoms." *Ibid*. Based on all the evidence, he further concluded that this respiratory impairment "is a contributing factor in his diminished maximum exercise capacity, and because of the strenuous nature of his last coal mine employment, he would be unable to perform his usual coal mine job due to his respiratory impairment." *Ibid*.

Dr. James' opinions are based upon, and supported by, Mr. Ulibarri's medical and employment histories, his symptoms of productive cough, wheeze, and shortness of breath with exertion, and a decline in arterial oxygen with exertion. DX 13, CX 4. His opinions are thus "documented" as required by the regulations. *Justice v. Director, OWCP*, *supra*. Furthermore, consistent with the court's holding in *Cornett v. Benham Coal, Inc.*, *supra*., he found that, despite the "mild" decline in arterial oxygen levels on exertion noted in the blood gas studies previously conducted on Mr. Ulibarri, Claimant's respiratory impairment was sufficient to totally disable him from returning to the "very strenuous physical demands" of his last coal mine job as a "utilityman." DX 13. His conclusions regarding the requirements of Claimant's last coal mine job are consistent with my findings in this regard, and I thus find that Dr. James' opinion is well-reasoned, supported by the objective clinical evidence, and entitled to substantial weight.

Also as noted above, Claimant was examined at the request of his counsel by Dr. Rose on January 20, 2005. CX 1. In addition to performing an examination of Claimant, and conducting various clinical tests, Dr. Rose reviewed other medical evidence including the report and clinical test results of Dr. Repsher's December 2003 and July 2000 examinations, and the report and clinical test results of Dr. James' examination in April 2003. *Id.* at 5-8. Like Dr. James, Dr. Rose concluded that Mr. Ulibarri was totally disabled by his 20 years of coal mine dust exposure, worsening symptoms of exertional dyspnea and productive cough, radiographic evidence of increasing profusion of upper lobe pneumoconiotic nodules and worsening pulmonary function.

Id. at 9-10. She specifically opined, like Dr. James, that Claimant's arterial blood gas study revealed a greater than expected decrease in pO_2 with exertion and that Claimant would not be able to perform the strenuous tasks of his prior job as a utilityman. *Id.* at 9. She also testified during her deposition that Claimant's pulmonary function testing showed a moderate reduction in diffusion capacity and that:

> The reduction in diffusion capacity reflects a decrease in the ability of the lung to perform its major function, which is gas exchange, so it reflects the decrease in the lung's ability to allow oxygen to diffuse across from the lung into the blood capillaries to be then distributed to the vital organs.

CX 7 at 18. When asked if the pulmonary function and arterial blood gas tests indicated a significant respiratory impairment on Claimant's part, she testified:

> In the context of Mr. Ulibarri, it does, in that he was required to perform very strenuous labor when he was working as a miner, and this abnormal decline and increase in hypoxemia with exercise would impair his ability to perform these very strenuous tasks as a coal miner.

Id. at 20. She clearly detected a worsening in Claimant's respiratory symptoms over time as shown by CT scan and chest x-ray evidence, pulmonary function testing, and arterial blood gas testing. *Id.* at 25. According to Dr. Rose, the oxygen desaturation on exercise is a result of an increasing profusion of pneumoconiotic opacities combined with a decline in his pulmonary function, *i.e.*, "the profusion of macules and nodules has impaired his lung's ability to meet the oxygen demands of exercise." *Id.* at 25-26. She further testified that Claimant's other symptoms, including his reduced diffusion capacity, shortness of breath on exertion, cough, and sputum production, were causally related to his coal mine dust-induced respiratory disease inasmuch as those symptoms "are all classic symptoms for coal workers' pneumoconiosis and/or silicosis, especially in the context of obvious worsening of that disease over time." *Id.* at 26-27.

Like the opinions of Dr. James, Dr. Rose's conclusions are based upon, and supported by, Mr. Ulibarri's medical and employment histories, clinical test results, and his symptoms of declining pulmonary function, reduced diffusion capacity, shortness of breath on exertion, cough, and sputum production. CX 1, CX 7. Her opinions are thus "documented" as required by the regulations. *Justice v. Director, OWCP*, *supra*. Furthermore, she credibly explained that Mr. Ulibarri's impairment of gas exchange would prevent him from performing the "very strenuous tasks [previously required of Claimant] as a coal miner." CX 7 at 20. Her understanding of the duties of Claimant's last coal mine job, like that of Dr. James, is consistent with my findings in this regard, and I thus find that Dr. Rose's opinion is well-reasoned, supported by the objective clinical evidence, and entitled to substantial weight.

In contrast to the opinions of Drs. James and Rose, Dr. Repsher concluded that Claimant had no pulmonary or respiratory impairment which was caused by, or related to, his 20 years of underground coal mining employment. He did conclude, however, that Claimant suffered from hypertensive cardiovascular disease which would "probably" not allow Claimant to perform sustained heavy exertion, but he further stated that such disease "has nothing to do with his

lungs." EX 8 at 20. For a variety of reasons, including those set forth below, I find that Dr. Repsher's opinions are contrary to the weight of the better reasoned and documented opinions of Drs. James and Rose.

As a preliminary matter, I note that all three of these physicians are highly qualified. Dr. James is board-certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine, and he is a NIOSH certified B-reader. CX 5. Likewise, Dr. Rose is board-certified in Internal Medicine, Pulmonary Medicine, and General Preventive/Occupational Medicine, and is a NIOSH certified B-reader. CX 2 at 2. Dr. Repsher is also a NIOSH B-reader and board-certified in, *inter alia*, Internal Medicine, Pulmonary Disease, and Critical Care Medicine. EX 6. There is thus little basis upon which to accord the opinion of one physician more weight than those of the others based on qualifications.[10]

With respect to the specific bases of these physicians' opinions, I note that Dr. Repsher agreed with Claimant's experts that results from arterial blood gas studies showing a decrease in pO_2, also referred to as exercise desaturation, can be related to coal-mine-dust-related lung disease, although he also stated that there are many other causes, most commonly heart disease, for that result as well. EX 8 at 39. Dr. Repsher concluded that the results of the arterial blood gas study he administered during the November 18, 2003 examination were "within normal limits for age and altitude." EX 2 at 2. He did not perform an exercise blood gas test because he concluded it was "contraindicated by Claimant's *significant underlying heart disease* and, according to the Department of Labor regulations, one does not do an exercise blood gas under those circumstances." EX 8 at 40 (italics added). This diagnosis appears to be based on a chest x-ray he reviewed in July 2000 and on the results of the echocardiogram administered by Dr. James during a stress test in 2003. *See, e.g*. EX 1 at 2, EX 8 at 19. However, Dr. Repsher's diagnosis of significant heart disease is not supported by the evidence of record and is expressly contradicted by the opinions of Drs. James and Rose.

Drs. James and Rose both performed arterial blood gas tests at rest *and* on exercise which documented a drop in oxygen level on exercise. These physicians found no evidence of heart disease and therefore found no reason not to perform an exercise study. The 2003 arterial blood gas study by Dr. James showed a change of 3.4 mm of mercury between rest and exercise while the 2005 study by Dr. Rose disclosed an even larger change of 7 mm of mercury between rest and exercise. According to Dr. James, it is normal for there to be no change or an *increase* in blood oxygen levels after exercise. CX 4 at 1. Both physicians concluded that, given the strenuous nature of Claimant's prior coal mine employment, the respiratory impairment shown

[10] While Dr. Repsher's curriculum vitae is certainly impressive and notes that he is presently the Medical Director of the Occupational & Environmental Lung Disease Program at Lutheran Medical Center in Wheat Ridge, Colorado, he did not elaborate during his deposition on his duties there or describe his involvement in diagnosing and treating coal miners and other patients who suffer from respiratory or pulmonary diseases. In contrast, Dr. Rose testified during her deposition that she has been on staff at National Jewish Hospital in Denver, Colorado, which she identified as "as the number one respiratory hospital in the United States," for 17 years and is, *inter alia*, director of the occupational and environmental lung disease clinic there as well as medical director of the Miners Clinic of Colorado at the hospital. Dr. Rose also testified that she has evaluated and treated coal miners for respiratory diseases throughout her 17 years at National Jewish Hospital, especially during the three years she has been involved with the Miners Clinic of Colorado. Given the record before me, I am inclined to accord Dr. Rose's opinions slightly more weight than the opinions of the other physicians in this case.

by his blood gas studies would render him totally disabled. *See, e.g.*, DX 12 at 4, CX 1 at 9-10, CX 4 at 2. Both physicians similarly concluded that the drop in blood oxygen levels on exercise shown by the test results was directly related to Claimant's coal workers' pneumoconiosis. *Ibid*.

With respect to whether Claimant suffered from heart disease of any kind, Dr. James noted in his original evaluation on behalf of DOL that Claimant had a history of high blood pressure with no history of heart disease. DX 12. His physical examination of Claimant revealed no abnormalities with respect to the heart. *Ibid*. Similarly, in his 2005 report prepared after reviewing the reports and test results of Drs. Repsher and Rose, he noted that the ECG from his 2003 examination showed *no evidence of cardiac limitation* and concluded Claimant's shortness of breath and decline in arterial oxygen levels on exercise were caused by his coal workers' pneumoconiosis. CX 4 at 2.

Similarly, Dr. Rose found no evidence to support a diagnosis of heart disease in the record. For example, in contrast to Dr. Repsher's conclusion that his July 2000 x-ray revealed evidence of an enlarged heart, Dr. Rose's report of examination notes that the CT chest scan she obtained in January 2005 showed "[t]he heart size is normal." CX 1 at 8. During her deposition, she also testified that she found no evidence of any abnormalities indicative of heart disease during her examination, although she did determine that Claimant had hypertension which is a risk factor for heart disease. CX 7 at 17, 27. She further testified that she saw no evidence of any heart disease in Dr. James' report of examination of Claimant in 2003, and that the ECG he administered at the time of his examination was normal. *Id.* at 22-23. Based on her review of all the medical evidence, she concluded:

> There is no evidence to support a diagnosis of cardiomyopathy or congestive heart failure in Mr. Ulibarri. I believe he did have a fleck of calcium in a coronary artery on a CT scan, which is a common finding, particularly in older men, but other than that, he had no evidence for cardiomyopathy or congestive heart failure whatsoever.

Id. at 28.

Dr. Rose also disagreed with Dr. Repsher's opinion that Mr. Ulibarri's shortness of breath on exertion was adequately explained by heart disease. CX 7 at 28. Dr. Rose explained that the echocardiogram upon which Dr. Repsher relied showed: a left ventricle which was normal in size and systolic function; no decrease in the left ventricular ejection fraction; and "very little . . . to support any evidence for diastolic heart failure or any evidence for cardiomyopathy." *Id.* at 30. Furthermore, according to Dr. Rose, the issue of diastolic dysfunction is highly controversial among cardiologists inasmuch as there is disagreement over whether it is clinically relevant and even how to define it. *Ibid*. She testified that even if one were to assume that Claimant's echocardiogram results revealed evidence of "a very early or very mild category of diastolic dysfunction, . . . it would in no way explain Mr. Ulibarri's respiratory symptoms, nor the findings on his high-resolution CT scan, nor would it explain his pulmonary function abnormalities or the decline in oxygen tension with his arterial blood gas testing, so the bottom line is this is a complete red herring, and has no relevance at all in terms of understanding or explaining Mr. Ulibarri's clinical finding." *Id.* at 31.

Dr. Repsher's diagnosis of heart disease also seems to be contradicted by his own reports of examination of Claimant. For example, his report of the July 24, 2000 examination notes that Claimant's heart and extremities were normal on physical examination with no signs of edema or abnormal heart sounds. DX 2. The results of his November 18, 2003 examination of Claimant at St. Mary Corwin Hospital were similarly "normal" with respect to the heart although an EKG reflected "diastolic dysfunction and *very mild pulmonary hypertension of no present clinical significance*." EX 2 at 2 (italics added). Finally, a November 18, 2003 chest x-ray obtained at the time of Dr. Repsher's examination was interpreted by Dr. DeGroot, a staff physician at St. Mary Corwin Hospital, as showing a normal sized heart, *i.e.*, "The cardiomediastinal silhouette and pulmonary vasculature are unremarkable."[11] CX 9.

Finally, Claimant testified that after he was examined by Dr. Repsher and told that he had a heart condition, he saw Dr. Loretta Conder, his treating physician at the Colfax Medical Center, and told her he "had a bad heart." Tr. 37. According to Mr. Ulibarri, Dr. Conder subsequently determinedthere was nothing wrong with his heart. *Ibid*.

Based on the foregoing, I find that the opinions of Drs. James and Rose are rationale, well reasoned, and well documented in that they are consistent with, and supported by, the objective medical evidence of record. I further find that these opinions effectively refute Dr. Repsher's contrary conclusion that Mr. Ulibarri's disability is caused by heart disease rather than any respiratory impairment caused by coal workers' pneumoconiosis, and that Dr. Repsher's opinions are thus entitled to little weight. In light of these findings, I further find that the preponderance of the newly submitted medical opinion evidence supports a finding of total disability under 20 C.F.R. § 718.204(b)(2)(iv).

Because Claimant demonstrated that one of the applicable conditions of entitlement has changed, it is necessary to consider the cumulative evidence and determine whether Claimant has established the four elements of entitlement under the Act. § 725.309.

Existence of Pneumoconiosis and Causation

Employer has stipulated, and I find based on a review of all the evidence of record, that Claimant suffers from coal workers' pneumoconiosis which arose out of his more than 20 years of underground coal mine employment.

Total Disability due to Pneumoconiosis

It is clear from the uncontradicted medical evidence associated with Claimant's first two claims for benefits that Claimant was not totally disabled before filing his instant claim. DX 1, DX 2. However, it is also clear that Claimant's condition has deteriorated over time as a result of his coal workers' pneumoconiosis and that he is now totally disabled.

[11] "Cardio" is simply a prefix referring to the heart and the "mediastinum" is "[t]he region in mammals between the pleural sacs [lungs], containing the heart and all of the thoracic viscera except the lungs." *See* http://dictionary.reference.com/browse/cardio and http://dictionary.reference.com/browse/mediastinum, visited June 13, 2006.

Chest x-ray evidence in 1996 reflected Category 1/0 simple pneumoconiosis with type q/q opacities in only the upper lung fields. DX 1. The next chest x-ray dated April 24, 2000 was read as showing Category 1/1 simple pneumoconiosis with type q/q opacities in the mid and upper lung zones bilaterally and the right lower lung. DX 2. Both Drs. James and Repsher interpreted the next x-ray, dated April 25, 2003, as showing Category 1/2 simple pneumoconiosis and, although Dr. James read the film as showing q/q opacities in all but the left lower lung zone, Dr. Repsher read it as revealing q/r opacities in *all* lung zones. DX 15, CX 11. Finally, a CT scan ordered by Dr. Rose at the time of her January 20, 2005 examination of Claimant revealed "[i]nnumerable small nodular opacities measuring 2-5 mm in diameter . . . throughout the lungs, but predominating in the upper and midlung zones." CX 3. These studies thus confirm an increase between 1996 and 2005 in Claimant's lungs of the profusion and location of opacities attributable to coal workers' pneumoconiosis.

Pulmonary studies over the years similarly document a decline in Mr. Ulibarri's pulmonary functioning between 1996 and 2005. For example, Claimant's pre-bronchodilator FEV_1 values from 1996 to 2000 declined from 3.40 to 2.99 and his pre-bronchodilator FVC values declined from 4.44 to 4.11. DX 1, DX 2. In 2005 the pre-bronchodilator FEV_1 value had further declined to 2.54 and his pre-bronchodilator FVC value was 3.14. CX 3. Dr. Rose concluded that these studies reflected a decline in pulmonary function over time that mirrored the increased perfusion of nodules seen on Claimant's CT scan which were associated with his worsening gas exchange and other symptoms. CX 7 at 25, 42-43. Dr. Repsher similarly acknowledged that the decline shown in the pulmonary studies reflected a "slow steady decline" which was "much greater than you would expect just from aging alone." EX 8 at 14-15. Although he also asserted that the January 2005 study by Dr. Rose was invalid based on "a gross lack of effort and cooperation with the testing ," EX 8 at 15, Dr. Rose testified that the results of the test prior to the administration of the bronchodilator were "unquestionably valid," as shown by the flow volume curves contained in the pulmonary function testing, and those results indicated a decline in his lung function. CX 7 at 42-43.

Finally, results from the arterial blood gas studies between 1996 and 2005 further demonstrate a decline in Claimant's oxygen blood levels after exercise. The 1996 study showed a decline in pO_2 levels from 72.7 at rest to 68.6 on exercise. DX 1. The 2003 study similarly showed a decline in pO_2 levels from 68.8 at rest to 63.4 on exercise. DX 13. Finally, the 2005 study performed by Dr. Rose showed a decline in pO_2 levels from 74 at rest to 67 on exercise.

Given the decline in Claimant's respiratory condition as documented by the above-referenced clinical tests, coupled with the well reasoned opinions of Drs. James and Rose, I find based on a review of all the record evidence, both new and old, that Claimant is totally disabled as a result of his respiratory impairment which was caused by his 20 years of underground coal mine employment.

Date of Onset

In a case such as this, in which the evidence does not establish the month of the onset of total disability, benefits are payable beginning with the month during which the claim was filed. 20 C.F.R. § 725.503(b). In this case, Claimant filed the instant claim on October 23, 2002.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, as no application has yet been received from his representative. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to §§ 725.365 and 725.366 of the Regulations. A service sheet showing service upon all parties, including the Claimant, must accompany the application. Parties have fifteen days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of ANDREW A. ULIBARRI for black lung benefits under the Act is hereby GRANTED, and it is hereby ORDERED that BASIN RESOURCES, INC., the Responsible Operator, shall pay to Claimant all augmented benefits to which he is entitled under the Act, commencing October 23, 2002.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the Office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601*. A copy of a notice of appeal must also be served on Allen Feldman, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.